Section 2699.6805 is amended to read:

Designation of Community Provider Plan

(a) For each benefit year, the Board will designate as the community provider plan in each county the participating health plan with a service area which includes zip codes in which at least eighty-five percent (85%) of the residents of the county reside that has the highest percentage of traditional and safety net providers pursuant to the calculation in (e) below.

(b) By the end of November of each year, the Board shall compile and make available a list for each county of all Child Health and Disability Prevention Program (CHDP), clinic and hospital traditional and safety net providers.

(c) The lists shall be compiled as follows:

(1) The CHDP list shall include all CHDP providers, except for clinical laboratories, that were on the Department of Health Services (DHS) CHDP Master File as of October 1st of that year and which provided a State-only funded CHDP service as identified on the CHDP Paid Claims Tape to at least one (1) child in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. For each provider, the list shall indicate the percentage of county children that received State-only funded CHDP services from the identified provider. The number of county children shall be calculated by summing the numbers of children that received State-only funded CHDP services from each listed provider.

(2) The clinic list shall include all community clinics, free clinics, rural health clinics, community hospital-based outpatient clinics and county owned and operated clinics, located in the county, which were so identified by the Medi-Cal program as of October 1st of that year and which were identified on the Medi-Cal Paid Claims Tape as having provided service to at least one (1) child aged one (1) through eighteen (18) in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. Only those community hospital-based outpatient clinics identified as having provided at least fifteen (15) services recorded on the Medi-Cal Paid Claims Tape for that year shall be included on the clinic list. For each clinic, the list shall indicate a percentage which shall be equal to:

(A) One (1) divided by the number of listed clinics in the county, multiplied by 0.225, plus

(B) The number of Medi-Cal funded services provided by the listed clinic divided by the number of Medi-Cal funded services provided to children by all listed clinics in each county, multiplied by 0.225.

(3) The hospital list shall include:

(A) For a county that has, located in the county, at least one hospital which was as of October 1st of that year a hospital eligible for the inpatient disproportionate share hospital payment program as reported by the Department of Health Services, a University teaching hospital, a Children's Hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital, the list shall include all hospitals of one of these types whether or not they are located in the county which reported to the Office of Statewide Health Planning and Development (OSHPD) discharging at least one resident of the county who was a Medi-Cal, county indigent and charity care patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge Data. For each hospital, the list shall indicate the percentage of the Medi-Cal, county indigent, and charity care discharges from all listed hospitals of county residents aged one (1) through eighteen (18) that were from the identified hospital.

(B) For all other counties, the list shall include all hospitals located in the county and all hospitals which discharged at least one resident of the county who was a Medi-Cal, county indigent or charity care patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge Data and which were a hospital eligible for the inpatient disproportionate share hospital payment program as reported by the DHS, a university teaching hospital, a children's hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital. For each hospital the list shall indicate the percentage of the Medi-Cal, county indigent, and charity care discharges from all listed hospitals of county residents aged one (1) through eighteen (18) that were from the identified hospital.

(d) By January 15th of each year, each participating health plan shall submit to the Board for each county the following:

(1) A list of the CHDP providers identified by the Board pursuant to (c)(1) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(2) A list of the clinics identified by the Board pursuant to (c)(2) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(3) A list of the hospitals identified by the Board pursuant to (c)(3) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(e) The percentage of traditional and safety net providers in the provider network of each participating health plan will be calculated by summing the CHDP percentage, the clinic percentage, and the hospital percentage.

(1) The CHDP percentage is calculated by summing the number of CHDP services provided to all children within the county as ~~percentages assigned to all CHDP providers in the county~~ identified by the plan pursuant to (d)(1) and dividing this sum by the number of services provided by all CHDP providers in that county and multiplying that number by 0.35.

~~(2) The clinic percentage is calculated by summing the percentages assigned to all clinics in the county identified by the plan pursuant to (d)(2), and multiplying that number by 0.45.~~

(2) The clinic percentage is calculated by:

(A) Dividing one (1) by the number of clinics in the county as identified by the plan pursuant to (d)(2), and multiplying that percentage by 0.225; and adding the number produced by the calculation made in subsection (e)(2)(B) below.

(B) Dividing the number of services provided by each clinic in the county identified by the plan pursuant to (d)(2) by the number of services provided by all listed clinics in the county pursuant to (c)(2), and multiplying that percentage by 0.225.

(3) The hospital percentage is calculated by summing the percentages assigned to all hospitals in the county identified by the plan pursuant to (d)(3), and multiplying that number by 0.2.

(f) The Board shall announce the designation of the community provider plan for each county by March 31st of each year for the benefit year beginning on the next July 1st. Prior to designation, each plan's relationships with traditional and safety net providers may be verified by the Board.

(g) The lists of CHDP providers in (c)(1), clinics in (c)(2) and hospitals in (c)(3) shall ~~only~~ be revised only under the following circumstances:

(1) Any CHDP provider not included on a county list pursuant to (c)(1) or any participating health plan that believes ~~it~~ the CHDP provider met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list described in subsection (b) is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the CHDP provider did meet the specified criteria it shall be added to the county list.

(2) Any clinic not included on a county list pursuant to (c)(2) or any participating health plan that believes ~~it~~ the clinic met the specified criteria to be on that list and was excluded in error, may, within thirty (30) calendar days after the list described in subsection (b) is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the clinic did meet the specified criteria it shall be added to the county list.

(3) Any hospital not included on a county list pursuant to (c)(3) or any participating health plan that believes ~~it~~ the hospital met the specified criteria to be on that list and was excluded in error~~,~~ may, within thirty (30) calendar days after the list described in subsection (b) is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the hospital did meet the specified criteria it shall be added to the county list.

HEALTHY FAMILIES PROGRAM
MANAGED RISK MEDICAL INSURANCE BOARD
COMMUNITY PROVIDER PLAN REGULATIONS
INITIAL STATEMENT OF REASONS

In 1997, the Federal Government established the State Children's Health Insurance Program (SCHIP), by adding Title XXI to the Social Security Act. California established a SCHIP insurance program, the Healthy Families Program (HFP), which is administered by the Managed Risk Medical Insurance Board (MRMIB), pursuant to AB 1126 (Chapter 623, Statutes of 1997). The program is targeted to serve children whose family income, although low, is too high to qualify for the Title XIX Medicaid Program, called Medi-Cal in California. The structure of the HFP is set out in Insurance Code Section 12693, et seq. and Chapter 5.8 of Title 10 of the California Code of Regulations.

AB 1126 contained provisions to ensure that MRMIB provide each HFP applicant a range of choice of providers, including Traditional and Safety Net (T&SN) providers. The objectives of the statute creating the CPP designation process included: 1) providing stability for the T&SN providers who had historically provided services to children who would qualify for the HFP when the Program began; 2) providing continuity of care for newly enrolled HFP members; 3) including providers in the HFP who share cultural and linguistic characteristics with the HFP population; and 4) encouraging plans to contract with many types of providers to ensure subscribers' access to services and choice among providers. MRMIB was directed to determine which plan in each county had done the best job of including T&SN providers in their network and to designate that plan the Community Provider Plan (CPP) for that county. For plans with a CPP designation, MRMIB allows a discount of $3 per child on the monthly family contribution (premium). All plans are encouraged to compete for the CPP designation by expanding their T&SN networks.

When the CPP process was under development, stakeholders provided input about the various methods that could be used to develop the T&SN lists and designate the CPP winner in each county. Based on that input, MRMIB adopted regulations to compile three separate lists of T&SN providers each year: 1) a list of T&SN hospitals (weighted 20 percent), 2) a list of T&SN clinics (weighted 45 percent), and 3) a list of T&SN Child Health and Disability Program (CHDP) providers (weighted 35 percent).

In 2006, several stakeholders submitted requests to change and/or clarify the CPP designation process. MRMIB has evaluated the stakeholders' requests and has determined that some of the recommendations would be of value in the CPP designation process.

At the July 19, 2006 Board meeting, MRMIB staff presented an analysis of proposed changes to the CPP designation process that health plans and stakeholders submitted earlier in 2006. These suggested changes included a recommendation that the Board adopt an algorithm used by the California Department of Health Services. Another suggestion was to totally exclude community hospital-based outpatient clinics. The majority of HFP health plans either did not respond or requested maintaining the status quo concerning the CPP designation process. Health plans and stakeholders that suggested changes were most concerned about which types of clinics to include on the T&SN lists and the process used for scoring clinics. Out of the three lists - the CHDP, clinic, and hospital lists - the clinic score receives the highest weighing factor, 0.45 of the total score.

After considering the analysis, the Board determined to make the following changes:

- Include community hospital-based outpatient clinics if they provided at least fifteen services during the measurement year.
- Split the clinic weighing factor between the number of T&SN clinics located in a county and the number of services each of the T&SN clinics provided.
- The first phase of developing the scores for the clinics would remain unchanged; the number of clinics would be divided into the number one (1) (representing 100 percent) but would be given half of the original scoring weight, or 0.225, rather than the original weighting factor of 0.45. The second phase of the scoring method would be to evaluate the number of services provided by each clinic, calculate a percentage, and apply the remaining scoring weight of 0.225. The sum of these two products represents the clinic score, still weighted at a total of 0.45.
- Clarify the scoring method related to CHDP providers by stating that the individual score is divided by the total score in each county to calculate the percentage applied to each CHDP provider
- Clarify that health plans, in addition to providers, are allowed to submit suggested changes to the T&SN lists during the 30-day appeal period in November each year

No changes are recommended for scoring the T&SN hospitals.

Article 4. RISK CATEGORIES AND FAMILY CONTRIBUTION

Section 2699.6805

Specific Purpose of the Change
Section 2699.6805, Designation of Community Provider Plan, explains the process MRMIB uses to select the Community Provider Plan (CPP) in each county. Amendments are being made to Section 2699.6805 in order to clarify the original intent of the CPP regulations, to clarify the CPP selection process, and to better target Traditional and Safety Net (T&SN) providers in each county.

Rationale for the Necessity of the Changes
Subsection 2699.6805(c)(2) is being amended to state specifically that community hospital-based outpatient clinics are included on the clinic list under specific circumstances. Many, but not all, community hospital-based outpatient clinics routinely provide services to low-income clients (the target population) and may be considered part of the (T&SN) provider system. To better identify the T&SN community hospital-based outpatient clinics, clinics must have provided no less than 15 services during the measurement year in order to be included on the T&SN clinic list. Subsection 2699.6805(c)(2) is amended to change the requirement, *for community hospital-based clinics only*, that clinics provide service to at least one (1) child in the Medi-Cal program to a requirement that community hospital-based outpatient clinics provide at least fifteen (15) services to children in the Medi-Cal program. Medi-Cal serves low income and culturally and linguistically diverse populations; therefore, using Medi-Cal as a proxy is an appropriate way to precisely define T&SN providers. This change will exclude clinics that rarely provide services to the target population or are not truly T&SN providers.

Subsections 2699.6805 (c)(2) and (e)(2) are being amended to modify the scoring method used for determining the weight given to each clinic. This change recognizes that not all clinics provide equal service and gives additional weight to clinics that provide more services to the target population. The current scoring method is being changed to equally recognize both the number of T&SN clinics in a county and the number of services provided by each T&SN clinic in the county. Retaining a portion of the weight for each T&SN clinic allows smaller clinics to continue to benefit by recognizing the services they provide to the target population.

Subsection 2699.6805 (e)(1) is being amended to clarify the method used for calculating the percentage attributed to each CHDP provider within each county.

Subsection 2699.6805(g) is being amended to specifically state that a health plan may submit documentation to MRMIB demonstrating that a provider should be included on one of the provider lists.

Data, Studies and Reports Relied Upon

- Memo from California Department of Health Services, June 29, 2005.
- Letter from Local Health Plans of California, April 21, 2006.
- Letter from CalOptima, July 14, 2006.
- Letter from Health Net, July 14, 2006.
- The Community Provider Plan Designation Process *Discussion of Issues Stakeholders Raised*, MRMIB Staff presented at July 19, 2006 Board Meeting
- Letter from Health Plan of San Joaquin, August 8, 2006.
- The Community Provider Plan Designation Process *Discussion of Stakeholders' Responses to Issue Paper Presented at the July 19, 2006 Meeting*, MRMIB Staff presented at September 20, 2006 Board Meeting.

The Community Provider Plan Designation Process
Discussion of Stakeholders' Responses To Issue Paper Presented at the July 19, 2006 Meeting

At the July 19, 2006 Board Meeting, MRMIB staff presented an analysis on the CPP designation process, stakeholders' proposed changes to the process, and MRMIB's recommendations, which included soliciting feedback from plans on the issues. Today we're updating the original report. Nine health plans submitted comments for consideration. The remaining HFP health plans, some of which do not participate in the CPP designation process, did not respond.

Review of Responses from Stakeholders and Staff's Recommendations

The original analysis focused on two issues that related to the T&SN Hospital List and three issues related to the T&SN Clinics list.

Hospital List

Issue 1: Should MRMIB continue to allow credit for out-of-county hospitals when they provide services to qualifying children who reside outside of the county where the hospital is located?

Historically, Local Initiative health plans that contract primarily with hospitals in their county have been most concerned about this issue. They believe it creates an unfair advantage for larger commercial plans that contract with hospitals throughout the State. Health Plan of San Joaquin requested that all out-of-county hospitals be removed from the list, except children's hospitals and other regional tertiary health care centers. San Francisco Health Plan requested all out-of-county hospitals be eliminated from the list.

Blue Cross and Community Health Group advocated that MRMIB should continue to allow credit for stays in out-of-county hospitals. Cal Optima also recommended maintaining the current method for generating the hospital score. Blue Shield and Molina stated that they did not have a specific opinion on making changes to the CPP designation process at this time. Santa Barbara Regional Health Authority stated their belief that proposed changes would not have a material impact on them.

Page three of the original report notes that the impact of eliminating out-of-county hospitals from the list would have little effect on the most current scores and would not alter the outcome of the competition for the current designations. Also noted is the elimination of these providers does not allow recognition of providers who provide services for HFP members who reside outside of the county of service or members who live in a county where there are no hospitals. Eliminating these hospitals removes one incentive for health plans to contract with some of the hospitals.

Staff recommends MRMIB continue to allow credit for out-of-county hospitals when they provide services to qualifying children who reside outside of the county where the hospital is located because this method recognizes hospitals that give care to Medi-Cal children, based on the number of services provided. This method reduces access obstacles for children who require services outside of their county of residence. Allowing this credit encourages plans to expand their networks to include more T&SN providers resulting in more choice for HFP members.

Issue 2: Should MRMIB replace the current method of generating the T&SN Hospital List with the method used by DHS?

Local Health Plans of California (LHPC) suggested adopting the method used by the California Department of Health Services (DHS) in their letter dated April 21, 2006. Their letter states that using this methodology, the hospital scoring would be based on discharges at Disproportionate Share Hospitals. See Attachment A for a copy of their letter.

Health Plan of San Joaquin supported the LHPC's proposal, but specifically stated children's hospitals should also be included, which differs from the DHS definition of T&SN hospitals. Blue Cross objects to adopting the DHS method, because it eliminates consideration of university/teaching, county owned and operated, and children's hospitals. They further state that enrollee choice would be reduced, hospitals may be financially harmed and the quality of the network for the Program could be impacted. Cal Optima and Community Health Group favor retention of the current method for generating hospital scores. Health Net objects to the DHS algorithm because it is not based on contracts.

The differences between the DHS and MRMIB methods are:

1. The purpose of the DHS method is to create criteria for assigning Medi-Cal members to health plans when no selection of a health plan is made by the applicant. The algorithm does not account for the number of contracts in a health plan's network, but rather accounts for the number of discharges from Disproportionate Share Hospitals.

In contrast, the purpose of the MRMIB method is to ensure that subscribers have access to T&SN providers and to ensure that there is a wide range of types of providers in HFP to allow continuity of care for new members who have received past care from T&SN providers.

2. The DHS method is based on the number of discharges from Disproportionate Share Hospitals (DSH). DSH are the only hospitals recognized by DHS as T&SN Hospital providers, although other types of hospitals, such as county owned and operated, children's, and university/teaching hospitals, provide services to a large number of Medi-Cal children. The DHS method is applied in only fourteen counties.

MRMIB's definition of T&SN Hospitals is much broader and includes university/teaching, county owned and operated, and children's hospitals, as well as DSH. All 58 California counties are evaluated and a hosital score is generated for services provided in each county.

3. The DHS method considers health plan HEDIS scores in its default methodology.

Although HEDIS quality measures are used to monitor quality improvement within the HFP, MRMIB does not consider HEDIS scores in the CPP designation process.

Staff recommends retaining the current method because the DHS method does not achieve the goals or intent of the CPP designation process.

Clinic List

Issue 1: Should MRMIB include or exclude Community Hospital-Based Outpatient Clinics (Provider Type 15) from the T&SN Clinic List?

In the past, MRMIB excluded Provider Type 15 from the T&SN Clinic List. Last year, staff interpreted HFP regulations to include these providers. The current regulations state that certain types of clinics are to be included, but do not state that **only** these types are to be included. Some providers in this category provide thousands of services to Medi-Cal children, less than 19 years of age. However, some of the providers report only a few such services in a one-year period, indicating that it was not part of their intended purpose to provide services to an indigent population. Under MRMIB's present method, plans get the same amount of credit for a clinic that has served one child as one that served a thousand.

Stakeholders' responses to the change in procedure are paraphrased as follows:

- **Exclude Provider Type 15**

  Health Plan of San Joaquin recommends including only clinics specifically referenced in the regulations. Cal Optima recommended no changes to the regulations regarding generation of the T&SN Clinic List, but requested that the interpretation of the regulations revert to the interpretation used in 2004 for the 2005-2006 designations. Cal Optima stated that many providers in this category are not truly T&SN providers and contends that regulatory history shows that "hospital outpatient clinics" were explicitly stricken from the final regulations. This is essentially the same as the recommendation from Health Plan of San Joaquin. San Francisco Health Plan and LHPC recommend MRMIB use the same criteria DHS uses for its Medi-Cal auto-assignment algorithm. These interpretations exclude Provider Type 15. Cal Optima also recommends that MRMIB continue to weigh the clinic scores equally within

each county, to protect small community clinics that are critical access points for health care services.

- **Continue to include Provider Type 15**

  Blue Cross and Community Health Group support using the current methodology, which includes Provider type 15 in the T&SN Clinic List. Health Net opposed the LHPC proposal to adopt the DHS algorithm as it relates to clinics and which would eliminate Provider Type 15 from the list. Health Net's objection was partly because the algorithm does not recognize individual providers as T&SN providers. Health Net further states that MRMIB might re-evaluate the current process of counting all of the clinics equally instead of weighting clinics based on their service to the safety net population.

Staff recommends amending the current regulations to include Provider Type 15 in the T&SN Clinic list and to modify the scoring method for clinics, because the current regulations are unclear and all clinics weigh equally within each county, but not all clinics are providing equal service.

Staff recommends dividing the current clinic score weight of 45 percent in half and applying a 22.5 percent weight using the current method to encourage health plans to continue to contract with small clinics and base the other 22.5 percent on the number of services provided. Clinics that provided fewer than 15 services during a one-year period will be excluded from the T&SN Clinic List. This method would continue to acknowledge smaller clinics that provide services in areas where access is important, but would reduce the impact of clinics that are not truly T&SN providers.

Staff further recommends the use the same criteria for developing the T&SN Clinic List used during 2004 for the 2005-2006 CPP designations be used for the upcoming process that begins in October for the 2007-2008 designations, while regulations are rewritten. Beginning next year for the 2008-2009 designations, it is recommended that Provider Type 15 be included in the T&SN Clinic List and the scoring routine be modified as noted above.

Issue 2: Should the same clinic appear more than once on the T&SN Clinic List?

Several plans registered concerns that some clinics that appear on the list more than once. MRMIB concurs that a unique clinic should appear only once on the list. Removing duplicates has been challenging and a method has not yet been devised to remove duplicates with 100 percent success. Abbreviations and variations in names and addresses make these fields unreliable for removing all duplicates from the list. Staff researched the provider identification field last year and found that often these identifiers

differ by only one character and are possibly related to the same clinic. DHS noted that often this reflects a change of ownership. This list will be generated again next month in October. MRMIB will examine the feasibility of a few different methods for removing duplicates from the list, while maintaining the list's usefulness as a tool for plans to use for matching.

Staff recommends MRMIB develop alternate methods for removing duplicates from the list and working with plans to ensure that their ability to match their providers with the T&SN Clinic List is not compromised.

Issue 3: Should methadone and optometry clinics be included in the T&SN Clinic List?

In its April 21, 2006 letter, LHPC notes that the DHS Medi-Cal enrollee auto-assignment process or algorithm identifies Federally Qualified Health Centers (FQHC's), Rural Health Centers, Indian or Tribal Clinics, and nonprofit community or free clinics licensed as primary are clinics by the State and they recommend that the same criteria be used for identifying T&SN clinics for the CPP designation process by MRMIB. This would exclude Provider Type 15 from the list.

LHPC and Health Net expressed concerns about the appearance of optometry and methadone clinics on the list. Correspondence did not specify the names of the particular clinics. LHPC was contacted and asked to identify the clinics in question for review, but due to changes in personnel LHPC has not yet identified the clinics.

Health Plan of San Joaquin and Health Net recommend that only clinics providing primary care be included on the list.

The process MRMIB currently uses to generate the T&SN Clinic List involves obtaining a list from DHS of Provider Types 15, 35, 40, 41, 45, 48 and 61, which are respectively, Community Outpatient Hospital Based, Rural Health (identified as FQHC's), Free, Community, Clinics Exempt from Licensure, County Clinics Not with a Hospital and County Hospital Outpatient Clinics. These are the only Provider Types that appear on the list requested from DHS. If other types of clinics, for example optometry or methadone clinics, appear on the list it is because the clinic was identified as one of the types listed above by DHS. No other Provider Types appear on the list. These types of clinics correspond to those used in the DHS algorithm with three exceptions, Community Outpatient Hospital Based Clinics, which are Provider Type 15, and Indian and Tribal Clinics, and Clinics Exempt from Licensure.

Indian and Tribal Clinics cannot be identified using the data currently provided by DHS to MRMIB. Although a list of Indian Health Clinics was available from DHS, DHS staff thought there was no way to isolate these clinics in a list of all clinics. The Indian and Tribal Clinic list had no Provider Type information, but did contain telephone numbers. A few clinics listed matched the names and addresses of clinics listed on the T&SN Clinic List; other clinics did not. Staff at a few clinics were contacted and, in some cases,

thought there was no affiliation between their clinic and other clinics that appeared on the original clinic list.

MRMIB did not specifically request that optometry, or methadone or Indian clinics be included in the clinic list. Although it is surprising that methadone and optometry clinics have appeared on the T&SN Clinic List, at present, there does not appear to be a means of electronically isolating the optometry, methadone, or Indian and Tribal clinics in the list.

Facilities exempt from licensure are Primary Care Clinics and therefore should be included in the T&SN Clinic List. These clinics are exempt from licensure for one of 16 reasons listed on Attachment B.

In comparing stakeholders' recommendations with criteria currently used by MRMIB:

1. MRMIB already includes all of the Provider Types in the recommendations, except some Indian and Tribal Clinics that could not be identified with a Provider Type.
2. MRMIB does intentionally include methadone or optometry clinics in the list which is in accord with stakeholders' recommendations.

Staff recommends no change in the method currently used in regards to methadone and optometry clinics, because there is no available method for isolating these types of clinics. Until the reason for the appearance of clinics such as these in the list is determined, it continues to be challenging to change procedure in a way that would guarantee that these types of providers would not appear in the list.

Currently 45 percent of total CPP score is attributed to contracts with clinics. This percent is to be divided in half; 22.5 percent will be based on the current method of scoring to encourage plans to continue to contract with small providers. The remaining 22.5 percent shall be attributed to the number of claims for Medi-Cal services provided to acknowledge clinics that provide a greater number of services than other clinics. Any clinic that saw fewer than 15 Medi-Cal children during a year will be deleted from the list and not considered

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June 18, 2007

Ms. Shelley Rouillard
Deputy Director
Benefits and Quality Monitoring Division
The California Managed Risk Medical Insurance Board
Po Box 2769
Sacramento, CA 95812

Dear Ms. Rouillard:

Thank you for the opportunity to review proposed changes to the Community Provider Plan (CPP) Regulations. Health Net of California is pleased to participate in the CPP program and to provide input on the regulations.

In reviewing the changes we have the following recommendations:

- **Please apply the 15 services minimum threshold to all clinic providers and not only the newly proposed community hospital-based clinics.** Screening all qualified clinics for at least a minimum of 15 services will assist in targeting the lists to those providers who actively serve the population.
- **Consider refining the clinic lists to include only those provider types who provide primary care services**. This could be accomplished by weighting clinics by the number of Children's Health Disability Prevention (CHDP) services provided. Given that Healthy Families is a program targeting children to keep them healthy with appropriate preventive care, it seems reasonable to conduct weighting to reflect providers who offer preventive, primary care services for children.
- **Consider refining the clinic lists to include only those providers who will contract with managed care health plans.** The CPP measures how many contracts health plans hold with the traditional and safety net providers. However, several County Health Department clinics appear on the lists even though they will not or cannot participate in managed care. For example, Sacramento County's Health Department clinics appear on the list even though Sacramento has a strong public policy position that they will not contract with any managed care plans. The County reserves their clinic resources for the medically indigent, those people who are completely without health insurance. Unfortunately, these clinics routinely appear on the CPP clinic list impacting the weight and scoring of all other Sacramento clinics. By removing such providers the remaining clinics will accurately reflect providers who wish to contract and participate as a safety net for the State's managed Medi-Cal and Healthy Families programs.

- **Consider removing or cleaning up the providers who routinely appear as duplicates on the lists.** For example, the aforementioned Sacramento County Health Department clinics appear twice, though both entries have the exact same address and exact same tax ID. Again, they dilute the weight of the other clinics while carrying a double score in the county.
- **The proposed CHDP provider percentage calculation has a potential error.** Previously, the CHDP providers were weighted by the *number of children* served who are residents of the county, regardless of location of the service delivery. The change seems to recommend weighting by the number of *services* provided to children who are residents of the county. However, the proposed numerator and denominator are not consistent. The numerator appears to count services delivered to a county's children by providers throughout the state, while the denominator clearly counts the number of CHDP providers in "…that county".

  Recommend either of the following:

  A) The CHDP percentage is calculated by summing the number of CHDP services *provided within the county to all children who are residents of the county*…and dividing this sum by the number of services provided *within the county by* CHDP providers in that county and multiplying that number by 0.35.

  B) The CHDP percentage is calculated by summing the number of CHDP services provided to *children who are residents of the county, regardless of location of service provider* … and dividing this sum by the number of services provided by all CHDP providers, *regardless of location of service provider.*

These are initial points Health Net requests the Board consider in its review of the current regulations and proposed changes. There may be other "clean-up" items that should be considered if the regulations are to be changed.

Health Net supports a review of these regulations to clarify and further define the process to identify and value traditional and safety net providers who wish to care for the Healthy Families or the managed Medi-Cal populations. To that end, we would prefer to a more comprehensive set of changes for consideration, even if that requires another year of CPP under the current set of regulations.

Thank you for the opportunity to present some of our observations and concerns on the proposed regulation changes.

Cordially,

Leah C. Morris, RN, MPH
Director, Provider Network Development
State Health Programs
Health Net of California

Cc: Dave Meadows